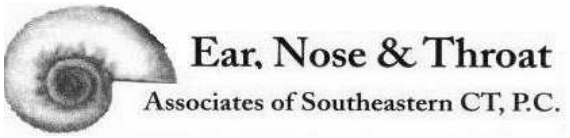
Name: _____
DOB: _____
Age: _____
Date: _____



SNORING AND SLEEP APNEA QUESTIONNAIRE

Do you wake frequently during the night and feel unrefreshed in the morning?	Yes ☐	No ☐
Do you have difficulty staying awake during the day?	Yes ☐	No ☐
Have you been told that you stop breathing, or gasp for breath while sleeping?	Yes ☐	No ☐
Are you overweight? Do you find it difficult to lose weight?	Yes ☐	No ☐
Do you wake up with a dry mouth, sore throat or headache in the morning?	Yes ☐	No ☐
Do you have difficulty concentrating during the day?	Yes ☐	No ☐
Do you need to take naps during the day?	Yes ☐	No ☐
Does your snoring bother you or your spouse enough for you to consider treatment?	Yes ☐	No ☐

Please rate how likely you are to doze off or fall asleep in the following situations:

	Never	Slight Chance	Moderate Chance	High Chance
1. Sitting and reading ……..	☐	☐	☐	☐
2. Watching T.V……..	☐	☐	☐	☐
3. Sitting inactive in a public place……..	☐	☐	☐	☐
4. As a car passenger for 1 hour without a break……	☐	☐	☐	☐
5. Lying down to rest in the afternoon……	☐	☐	☐	☐
6. Sitting & talking to someone……..	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol……..	☐	☐	☐	☐
8. In a car, while stopping for a few minutes in a traffic….	☐	☐	☐	☐